General

Guideline Title

Practice guidelines for the psychiatric evaluation of adults, third edition.

Bibliographic Source(s)

American Psychiatric Association (APA). Practice guidelines for the psychiatric evaluation of adults, third edition. Arlington (VA): American Psychiatric Association (APA); 2015. 164 p. [329 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Psychiatric Association (APA). Practice guideline for the psychiatric evaluation of adults. 2nd ed. Washington (DC): American Psychiatric Association (APA); 2006 Jun. 62 p. [302 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Recommendations

Major Recommendations

The definitions for the strength of the recommendations (recommendation [1] or suggestion [2]) and the strength of evidence (high [A], moderate [B], or low [C]) are provided at the end of the "Major Recommendations" field.

Guideline I. Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History

Guideline Statements

Statement 1. The American Psychiatric Association (APA) recommends (1C) that the initial psychiatric evaluation of a patient include review of the patient's mood, level of anxiety, thought content and process, and perception and cognition.

Statement 2. APA recommends (1C) that the initial psychiatric evaluation of a patient include review of the patient's trauma history.

Statement 3. APA recommends (1C) that the initial psychiatric evaluation of a patient include review of the following aspects of the patient's psychiatric treatment history:

- Past and current psychiatric diagnoses
- Past psychiatric treatments (type, duration, and, where applicable, doses)
- Adherence to past and current pharmacological and nonpharmacological psychiatric treatments

- Response to past psychiatric treatments
- History of psychiatric hospitalization and emergency department visits for psychiatric issues (as recommended in "Guideline III: Assessment of Suicide Risk" and "Guideline IV: Assessment of Risk for Aggressive Behaviors")

Guideline II. Substance Use Assessment

Guideline Statement

APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the patient's use of tobacco, alcohol, and other substances (e.g., marijuana, cocaine, heroin, hallucinogens) and any misuse of prescribed or over-the-counter medications or supplements.

Guideline III. Assessment of Suicide Risk

Guideline Statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:

- Current suicidal ideas, suicide plans, and suicide intent, including active or passive thoughts of suicide or death
- Prior suicidal ideas, suicide plans, and suicide attempts, including attempts that were aborted or interrupted
- Prior intentional self-injury in which there was no suicide intent
- Anxiety symptoms, including panic attacks
- Hopelessness
- Impulsivity
- History of psychiatric hospitalization and emergency department visits for psychiatric issues
- Current or recent substance use disorder or change in use of alcohol or other substances
- Presence of psychosocial stressors (e.g., financial, housing, legal, school/occupational or interpersonal/relationship problems; lack of social support; painful, disfiguring, or terminal medical illness)
- Current aggressive or psychotic ideas, including thoughts of physical or sexual aggression or homicide (as recommended in "Guideline IV: Assessment of Risk for Aggressive Behaviors")
- Mood, level of anxiety, thought content and process, and perception and cognition (As recommended in "Guideline I: Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History")
- Past and current psychiatric diagnoses (as recommended in "Guideline I: Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History")
- Trauma history (as recommended in "Guideline I: Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History")

Statement 2. APA recommends (1C) that the initial psychiatric evaluation of a patient *who reports current suicidal ideas* include assessment of the following:

- Patient's intended course of action if current symptoms worsen
- Access to suicide methods, including firearms
- Patient's possible motivations for suicide (e.g., attention or reaction from others; revenge, shame, humiliation, delusional guilt, command hallucinations)
- Reasons for living (e.g., sense of responsibility to children or others, religious beliefs)
- Quality and strength of the therapeutic alliance
- History of suicidal behaviors in biological relatives

Statement 3. APA recommends (1C) that the initial psychiatric evaluation of a patient *who reports prior suicide attempts* includes assessment of the details of each attempt (e.g., context, method, damage, potential lethality, intent).

Statement 4. APA recommends (1C) that the clinician who conducts the initial psychiatric evaluation document an estimation of the patient's suicide risk, including factors influencing risk.

Guideline IV. Assessment of Risk for Aggressive Behaviors

Guideline Statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:

- Current aggressive or psychotic ideas, including thoughts of physical or sexual aggression or homicide
- Prior aggressive or psychotic ideas, including thoughts of physical or sexual aggression or homicide

- Past aggressive behaviors (e.g., homicide, domestic or workplace violence, other physically or sexually aggressive threats or acts)
- Legal or disciplinary consequences of past aggressive behaviors
- History of psychiatric hospitalization and emergency department visits for psychiatric issues
- Current or recent substance use disorder or change in use of alcohol or other substances
- Presence of psychosocial stressors
- Exposure to violence or aggressive behavior, including combat exposure or childhood abuse
- Past or current neurological or neurocognitive disorders or symptoms

Statement 2. When it is determined during an initial psychiatric evaluation that the patient has aggressive ideas, APA recommends (1C) assessment of the following:

- Impulsivity, including anger management issues
- Access to firearms
- Specific individuals or groups toward whom homicidal or aggressive ideas or behaviors have been directed in the past or at present
- History of violent behaviors in biological relatives

Statement 3. APA suggests (2C) that the clinician who conducts the initial psychiatric evaluation should document an estimation of risk of aggressive behavior (including homicide), including factors influencing risk.

Guideline V. Assessment of Cultural Factors

Guideline Statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the patient's need for an interpreter.

Statement 2. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of cultural factors related to the patient's social environment.

Statement 3. APA suggests (2C) that the initial psychiatric evaluation of a patient include assessment of the patient's personal/cultural beliefs and cultural explanations of psychiatric illness.

Guideline VI. Assessment of Medical Health

Guideline Statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of whether or not the patient has an ongoing relationship with a primary care health professional.

Statement 2. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of the following:

- General appearance and nutritional status
- Involuntary movements or abnormalities of motor tone
- Coordination and gait
- Speech, including fluency and articulation
- Sight and hearing
- Physical trauma, including head injuries
- Past or current medical illnesses and related hospitalizations
- Relevant past or current treatments, including surgeries, other procedures, or complementary and alternative medical treatments
- Allergies or drug sensitivities
- Sexual and reproductive history
- Past or current sleep abnormalities, including sleep apnea

Statement 3. APA recommends (1C) that the initial psychiatric evaluation of a patient include assessment of all medications the patient is currently or recently taking (i.e., both prescribed and nonprescribed medications, herbal and nutritional supplements, and vitamins) and the side effects of these medications.

Statement 4. APA suggests (2C) that the initial psychiatric evaluation of a patient also include assessment of the following:

- Height, weight, and body mass index (BMI)
- Vital signs

- Skin, including any stigmata of trauma, self-injury, or drug use
- Cardiopulmonary status
- Past or current endocrinological disease
- Past or current infectious disease, including sexually transmitted diseases, human immunodeficiency virus (HIV), tuberculosis, hepatitis C, and locally endemic infectious diseases such as Lyme disease
- Past or current neurological or neurocognitive disorders or symptoms
- Past or current symptoms or conditions associated with significant pain and discomfort

Statement 5. In addition to a psychiatric review of systems (as recommended in "Guideline I. Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History"), APA suggests (2C) that the initial psychiatric evaluation of a patient include a review of the following systems:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Endocrine
- Hematological/lymphatic
- Allergic/immunological

Guideline VII. Quantitative Assessment

Guideline Statement

APA suggests (2C) that the initial psychiatric evaluation of a patient include quantitative measures of symptoms, level of functioning, and quality of life.

Guideline VIII. Involvement of the Patient in Treatment Decision Making

Guideline Statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient who is seen include an explanation to the patient of the following: the differential diagnosis, risks of untreated illness, treatment options, and benefits and risks of treatment.

Statement 2. APA recommends (1C) that the initial psychiatric evaluation of a patient who is seen include asking the patient about treatment-related preferences.

Statement 3. APA recommends (1C) that the initial psychiatric evaluation of a patient who is seen include collaboration between the clinician and the patient about decisions pertinent to treatment.

Guideline IX. Documentation of the Psychiatric Evaluation

Guideline Statements

Statement 1. APA recommends (1C) that the initial psychiatric evaluation of a patient include documentation of the rationale for treatment selection, including discussion of the specific factors that influenced the treatment choice.

Statement 2. APA suggests (2C) that the initial psychiatric evaluation of a patient include documentation of the rationale for clinical tests.

Definitions

Rating the Strength of the Recommendations

"Recommendation" (*denoted by the numeral 1 after the guideline statement*) indicates confidence that the benefits of the intervention clearly outweigh harms.

"Suggestion" (*denoted by the numeral 2 after the guideline statement*) indicates uncertainty (i.e., the balance of benefits and harms is difficult to judge or either the benefits or the harms are unclear).

Rating the Strength of Supporting Research Evidence

High (*denoted by the letter A*) = High confidence that the evidence reflects the true effect. Further research is very unlikely to change confidence in the estimate of effect.

Moderate (*denoted by the letter B*) = Moderate confidence that the evidence reflects the true effect. Further research may change confidence in the estimate of effect and may change the estimate.

Low (*denoted by the letter C*) = Low confidence that the evidence reflects the true effect. Further research is likely to change confidence in the estimate of effect and is likely to change the estimate.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Psychiatric disorders

Guideline Category

Diagnosis

Evaluation

Clinical Specialty

Psychiatry

Intended Users

Physicians

Guideline Objective(s)

- To improve the identification of psychiatric signs and symptoms, psychiatric disorders (including substance use disorders), other medical conditions (that could affect the accuracy of a psychiatric diagnosis), and patients who are at increased risk for suicidal or aggressive behaviors
- To help identify factors that could influence the therapeutic alliance, enhance clinical decision making, enable safe and appropriate treatment planning, and promote better treatment outcomes
- To improve collaborative decision making between patients and clinicians about treatment-related decisions as well as to increase coordination of psychiatric treatment with other clinicians who may be involved in the patient's care

Target Population

Adult patients with a psychiatric symptom, sign, or syndrome presenting for psychiatric evaluation

Interventions and Practices Considered

1. Review of psychiatric symptoms, trauma history, and psychiatric treatment history
2. Substance use assessment
3. Assessment of suicide risk
4. Assessment of risk for aggressive behaviors
5. Assessment of cultural factors
6. Assessment of medical health
7. Quantitative assessment of symptoms, level of functioning, and quality of life
8. Involvement of the patient in treatment decision making
9. Documentation of the psychiatric evaluation

Major Outcomes Considered

- Prevalence of substance use disorders in patients with psychiatric disorders
- Identification and diagnosis of substance use disorders based on psychiatric evaluation
- Identification of risk for suicide based on initial psychiatric evaluation
- Benefits of a suicide risk assessment in reducing rates of suicide or suicide attempts
- Benefits of structured risk assessment for aggression in reducing aggressive/violent incidents
- Ability of a screening history, physical examination, or battery of tests on the identification of medical causes of psychiatric symptoms
- Sensitivity and specificity of quantitative measures (measures of symptoms, level of functioning, quality of life, adverse effects of treatment) in clinical decision making
- Improvement in therapeutic alliance and treatment adherence by shared decision-making and patient involvement

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Systematic Review Methodology

These guidelines are based on a systematic search of available research evidence.

Systematic searches were conducted of the MEDLINE (PubMed), PsycINFO (EBSCOHost), and Cochrane (Wiley) databases. The search terms and limits used are available on request from the American Psychiatric Association (APA).

Search strategies were constructed that included a full range of topics related to psychiatric evaluation given the expected overlap in the retrieved literature for specific guideline questions. An initial search of MEDLINE was conducted in October 2010. This search yielded 250,981 articles. A second set of searches was conducted in October 2011. These searches yielded 32,895 articles in MEDLINE, 7,052 articles in PsycINFO, and 5,986 articles in the Cochrane database. All searches were done for the years from 1900 to the time of the search.

One individual screened 95,166 references from the 2010 search, spanning the years from 2005 to 2010. A second individual screened the 32,895 references from the 2011 search after duplicate articles from the different searches were eliminated. Included articles were those that pertained to a clinical trial (including a controlled or randomized trial), observational study, meta-analysis, or systematic review and were clinically relevant to psychiatric evaluation (i.e., relevant to any possible clinical question that might be addressed by potential APA practice guidelines). Excluded references included articles on nosology of psychiatric disorders, risk factors or associated features of specific disorders, potential etiologies of specific disorders, and course and prognosis of specific disorders. Studies of psychiatric treatments were included only if they also included information about the specific effects of psychiatric evaluation. Due to the large number of articles that were screened, the specific reasons for exclusion or inclusion of each article were not recorded.

A total of 5,073 articles met the broad inclusion criteria. These articles were screened for relevance to the clinical questions formulated for these guidelines and described under "Review of Supporting Research Evidence: Clinical Questions" in the original guideline document.

For inclusion, a study needed to address an appropriate population of patients in a psychiatric setting who were receiving a psychiatric evaluation. Studies of patients who were seen by psychiatric consultants in a medical setting were included. The "intervention" was considered to be assessing a patient for a specific element of the evaluation. The "comparator" could include care as usual and was sometimes non-specific. The "outcomes" used were those specified by the PICOTS (Population, Intervention, Comparison, Outcome, Time, Setting) questions. Given the limited number of studies that addressed effects of psychiatric evaluation, reviewers erred on the side of using broader definitions of comparators, outcomes and assessment timing. However, studies of sensitivity and specificity of rating scales as compared to structured interviews were not included unless they specifically addressed a discrete PICOTS "outcome."

An update of the literature search was conducted in September 2014 using the same databases and search strategies used for the October 2011 search. These searches in September 2014 yielded 8,521 additional articles in MEDLINE, 1,980 additional articles in PsycINFO, and 1,310 additional articles in the Cochrane database. After duplicates were eliminated, 11,644 abstracts were screened for relevance by two individuals. A total of 65 additional references met the broad inclusion criteria, and of these, 1 study was relevant to quantitative assessment.

For supporting sections of these guidelines (e.g., rationale, implementation), additional targeted searches of the literature were conducted to identify relevant references.

Number of Source Documents

The total number of studies that were agreed to have relevance to the Population, Intervention, Comparison, Outcome, Time (PICOT) question for each guideline topic is as follows:

- 0 studies for Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History
- 4 studies for Substance Use Assessment
- 1 study for Assessment of Suicide Risk
- 2 studies for Assessment of Risk for Aggressive Behaviors
- 0 studies for Assessment of Cultural Factors
- 3 studies for Assessment of Medical Health
- 3 studies for Quantitative Assessment
- 17 studies for Involvement of the Patient in Treatment Decision Making
- 0 studies for Documentation of the Psychiatric Evaluation

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Rating the Strength of Supporting Research Evidence

High (*denoted by the letter A*) = High confidence that the evidence reflects the true effect. Further research is very unlikely to change confidence in the estimate of effect.

Moderate (*denoted by the letter B*) = Moderate confidence that the evidence reflects the true effect. Further research may change confidence in the estimate of effect and may change the estimate.

Low (*denoted by the letter C*) = Low confidence that the evidence reflects the true effect. Further research is likely to change confidence in the estimate of effect and is likely to change the estimate.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

"Strength of supporting research evidence" describes the level of confidence that findings from scientific observation and testing of an effect of an intervention reflect the true effect. Confidence is enhanced by factors such as rigorous study design and minimal potential for study bias. Three ratings are used: high, moderate, and low (see the "Rating Scheme for the Strength of the Evidence" field).

Ratings are determined by the Systematic Review Group, after assessment of available clinical trials across four primary domains: risk of bias, consistency of findings across studies, directness of the effect on a specific health outcome, and precision of the estimate of effect.

Methods Used to Formulate the Recommendations

Expert Consensus (Delphi)

Description of Methods Used to Formulate the Recommendations

These guidelines were developed using a process intended to meet standards of the Institute of Medicine (2011). The process is fully described in a document available on the American Psychiatric Association (APA) Web site .

Work Group Composition

Because these guidelines addressed aspects of a psychiatric evaluation, the work group was composed of psychiatrists. However, some experts from other disciplines were included in the expert panel that was surveyed, as described under "Expert Opinion Data Collection" below. The work group was diverse and balanced with respect to their expertise as well as other characteristics, such as geographical location and demographic background. Methodological expertise (i.e., with respect to appraisal of strength of research evidence) was provided by the Systematic Review Group. A patient advocate was involved as an advisor during question formulation and draft review.

Expert Opinion Data Collection

An expert opinion survey was fielded to a panel of 1,738 experts in psychiatric evaluation and management. The response rate for the survey was 45.1% (n=784); 8.4% of the responses were partial, meaning that at least one of the eight sections of the survey was completed. Members of the panel were peer-nominated in 2011 by current and past APA work group members, chairs of academic departments of psychiatry and directors of psychiatry residency programs in the United States and Canada, and the APA Assembly. Survey questions were adapted from clinical questions developed by an APA expert work group and reviewed by a multidisciplinary group of stakeholders. The survey included questions to address which types of assessments improve identification of patients at risk for suicide and whether the experts typically perform such assessments in practice.

Nominators were asked to identify two types of experts to serve on the panel: researchers and clinicians. "Research experts" were defined as individuals who are making substantial contributions, via research or scholarly writing, to the area of psychiatric evaluation and management. "Clinical experts" were defined as individuals who have substantial clinical experience in the psychiatric evaluation of adults or an expert clinician whom the nominator might consult about an adult patient with a complex presentation. The panel was composed of approximately 70% clinical experts, 20% research experts, and 10% experts in both categories. Most of the panel members, 76.4%, were nominated once, 14.8% were nominated twice, and the remainder were nominated up to nine times. The majority of the panel members were contacted via email to complete the survey online; 1.8% were contacted via mail and 0.6% were not contacted because of lack of email or mailing address or inability to distinguish the intended nominee because of common names.

The composition of the portion of the panel who responded to the survey corresponds closely with that of the entire panel, within 0%–4% (i.e., in the number of times panel members were nominated and whether they were identified as clinical or research experts or both).

For each guideline, quantitative data from the survey are shown under "Review of Available Evidence" in the original guideline document. The survey also collected many free text comments, which were reviewed during development of the draft guidelines. Key themes from qualitative data have been incorporated into the implementation section of the guideline.

Rating the Strength of Recommendations

Each guideline statement is separately rated to indicate strength of recommendation and strength of supporting research evidence.

"Strength of recommendation" describes the level of confidence that potential benefits of an intervention outweigh potential harms. This level of confidence is informed by available evidence, which includes evidence from clinical trials as well as expert opinion and patient values and preferences. The rating is a consensus judgment of the authors of the guideline and is endorsed by the APA Board of Trustees.

There are two possible ratings: recommendation or suggestion. These correspond to ratings of "strong" or "weak" (also termed "conditional") as defined under the GRADE (Grading of Recommendations Assessment, Development and Evaluation) method for rating recommendations in clinical practice guidelines (described in publications such as Guyatt et al. 2008 and others available on the Web site of the GRADE Working Group at http://www.gradeworkinggroup.org/). See the "Rating Scheme for the Strength of the Recommendations" field.

When a negative statement is made, ratings of strength of recommendation should be understood as meaning the inverse of the above (e.g., "recommendation" indicates confidence that harms clearly outweigh benefits).

When there is insufficient information to support a recommendation or a suggestion, a statement may be made that further research about the intervention is needed.

The work group determined ratings of strength of recommendation by the Delphi method—that is, through blind, iterative voting and discussion. In weighing potential benefits and harms, the group considered the strength of supporting research evidence, the results of the expert opinion survey, and their own clinical experiences and opinions. For recommendations, at least seven of the eight members of the group must have voted to "recommend" the intervention or assessment after three rounds of voting. If this level of consensus was not achieved, the work group could agree to make a "suggestion" rather than a recommendation. No suggestion or statement was made if three or more work group members voted "no statement." Differences of opinion within the group about ratings of strength of recommendation, if any, are described under "Review of Available Evidence" in the original guideline document.

Rating Scheme for the Strength of the Recommendations

Rating the Strength of the Recommendations

"Recommendation" (*denoted by the numeral 1 after the guideline statement*) indicates confidence that the benefits of the intervention clearly outweigh harms.

"Suggestion" (*denoted by the numeral 2 after the guideline statement*) indicates uncertainty (i.e., the balance of benefits and harms is difficult to judge or either the benefits or the harms are unclear).

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

External Review

These guidelines were made available for review in January 2014 by stakeholders, including the American Psychiatric Association (APA) membership, scientific and clinical experts, allied organizations (including patient advocacy organizations), and the public. Eighty-seven individuals and 10 organizations submitted comments on one or more topics of the psychiatric evaluation guidelines. The work group reviewed and addressed all comments received. Revisions to ratings of strength of recommendation were determined by new Delphi voting.

Approval

These guidelines were submitted to the APA Board of Trustees for approval on December 14, 2014.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

The second section of the Practice Guidelines provides a detailed review of the evidence for all guideline statements in accord with national guideline development standards.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Improved psychological and social functioning

The balance of benefits and harms was assessed for each recommendation. Refer to the "Potential Benefits and Harms" sections in the original guideline document for a discussion of specific benefits of each guideline recommendation.

Potential Harms

Unneeded treatment resulting from false diagnosis

The balance of benefits and harms was assessed for each recommendation. Refer to the "Potential Benefits and Harms" sections in the original guideline document for a discussion of potential harms of each guideline recommendation.

Qualifying Statements

Qualifying Statements

The authors have worked to ensure that all information in this book concerning drug dosages, schedules, and routes of administration is accurate as of the time of publication and consistent with standards set by the U.S. Food and Drug Administration and the general medical community. As medical research and practice advance, however, therapeutic standards may change. For this reason and because human and mechanical errors sometimes occur, the authors recommend that readers follow the advice of a physician who is directly involved in their care or the care of a member of their family.

Proper Use of Guidelines

The American Psychiatric Association (APA) Practice Guidelines are not intended to serve or be construed as a "standard of medical care." Judgments concerning clinical care depend on the clinical circumstances and data available for an individual patient and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These guideline statements were determined on the basis of the relative balance of potential benefits and harms of a specific assessment, intervention, or other approach to care. As such, it is not possible to draw conclusions about the effects of omitting a particular recommendation, either in general or for a specific patient. Furthermore, adherence to these guidelines will not ensure a successful outcome for every individual, nor should these guidelines be interpreted as including all proper methods of evaluation and care or excluding other acceptable methods of evaluation and care aimed at the same results. The ultimate recommendation regarding a particular assessment, clinical procedure, or treatment plan must be made by the psychiatrist in light of the psychiatric evaluation, other clinical data, and the diagnostic and treatment options available. Such recommendations should be made in collaboration with the patient and family, whenever possible, and incorporate the patient's personal and sociocultural preferences and values in order to enhance the therapeutic alliance, adherence to treatment, and treatment outcomes.

Implementation of the Guideline

Description of Implementation Strategy

Implementation strategies are provided for each guideline topic throughout the original guideline document.

Implementation Tools

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

American Psychiatric Association (APA). Practice guidelines for the psychiatric evaluation of adults, third edition. Arlington (VA): American Psychiatric Association (APA); 2015. 164 p. [329 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1995 (revised 2015)

Guideline Developer(s)

American Psychiatric Association - Medical Specialty Society

Source(s) of Funding

American Psychiatric Association (APA)

Guideline Committee

American Psychiatric Association (APA) Work Group on Psychiatric Evaluation

APA Steering Committee on Practice Guidelines

Composition of Group That Authored the Guideline

APA Work Group on Psychiatric Evaluation: Joel J. Silverman, MD (*Chair*); Marc Galanter, MD; Maga Jackson-Triche, MD, MSHS; Douglas G. Jacobs, MD; James W. Lomax II, MD; Michelle B. Riba, MD; Lowell D. Tong, MD; Katherine E. Watkins, MD, MSHS

Systematic Review Group: Laura J. Fochtmann, MD, MBI; Richard S. Rhoads, MD; Joel Yager, MD

APA Steering Committee on Practice Guidelines: Michael J. Vergare, MD (*Chair*); James E. Nininger, MD (*Vice-Chair*); Thomas J. Craig, MD; Deborah Cowley, MD; Nassir Ghaemi, MD, MPH; David A. Kahn, MD; John M. Oldham, MD; Carlos N. Pato, MD, PhD; Mary S. Sciutto, MD

Financial Disclosures/Conflicts of Interest

Management of Potential Conflicts of Interest

Work group members were required to disclose all potential conflicts of interest before appointment, before and during guideline development, and on publication. As described below, no member of the work group reported any conflicts of interest with his or her work on these guidelines. The two members of the Systematic Review Group also reported no conflicts of interest.

Disclosures

The Work Group on Psychiatric Evaluation and the Systematic Review Group reported the following conflicts of interest during development and approval of these guidelines, from May 2011 to December 2014:

- Dr. Silverman is employed as a professor at Virginia Commonwealth University. He provides expert testimony to courts. He reports no conflicts of interest with his work on these guidelines.
- Dr. Galanter is employed as a professor at the New York University Medical School. He reports no conflicts of interest with his work on these guidelines.
- Dr. Jackson-Triche is employed as the chief mental health officer for the Sierra Pacific Network (VISN 21) of the U.S. Department of Veterans Affairs and as a professor at the University of California, Davis. She receives royalties from McGraw-Hill. She reports no conflicts of interest with her work on these guidelines.
- Dr. Jacobs is a psychiatrist in private practice and on the faculty of Harvard Medical School, and provides medical-legal consultation, including expert testimony, on suicidality in psychiatric disorders, suicide causation, and related areas. He is the president of Screening for Mental Health and founder of National Depression Screening Day. He reports no conflicts of interest with his work on these guidelines.
- Dr. Lomax is employed as a professor at Baylor College of Medicine. He reports no conflicts of interest with his work on these guidelines.
- Dr. Riba is employed as a professor at the University of Michigan. She receives royalties from American Psychiatric Publishing, Saunders, Wiley, and Guilford. She reports no conflicts of interest with her work on these guidelines.
- Dr. Tong is employed as a professor at the University of California, San Francisco. He receives royalty payments from Elsevier Publishing. He receives honoraria and travel funds from the National Board of Medical Examiners for test development. He reports no conflicts of interest with his work on these guidelines.
- Dr. Watkins is employed as a researcher at the RAND Corporation and is a psychiatrist in private practice. She reports no conflicts of interest with her work on these guidelines.
- Dr. Fochtmann is employed as a professor at Stony Brook University. She consults for the American Psychiatric Association (APA) on the development of practice guidelines. She has served as a stakeholder and as a technical expert panel member for AHRQ reviews related to psychiatric topics. She reports no conflicts of interest with her work on these guidelines.

- Dr. Rhoads is employed an assistant professor at the University of Arizona and as a medical director for the University of Arizona Medical Center, South Campus, and the Crisis Response Center. He consults for the APA on the development of practice guidelines. He reports no conflicts of interest with his work on these guidelines.
- Dr. Yager is employed as a professor at the University of Colorado. He reports no conflicts of interest with his work on these guidelines.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: American Psychiatric Association (APA). Practice guideline for the psychiatric evaluation of adults. 2nd ed. Washington (DC): American Psychiatric Association (APA); 2006 Jun. 62 p. [302 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the PsychiatryOnline Web site.

Availability of Companion Documents

The following is available:

- Practice guidelines for the psychiatric evaluation of adults, third edition. Executive summary. Arlington (VA): American Psychiatric Association (APA); 2015. Available from the PsychiatryOnline Web site.

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on December 1, 1998. The information was verified by the guideline developer on January 11, 1999. This summary was updated by ECRI on July 5, 2006. The updated information was verified by the guideline developer on August 10, 2006. The currency of the guideline was reaffirmed by the developer in 2011 and this summary was updated by ECRI Institute on December 1, 2011. This summary was updated again by ECRI Institute on October 9, 2015. The updated information was verified by the developer on October 29, 2015.

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